Time Start Restraints:							Time End Restraints:						
Medical Order Obtained: () Yes													
LOC/ORIENTATION: 1. AWAKE/ALERT 2. SLEEPING 3. CONFUSED 4. LETHARGIC 5. COMA		1. A 2. IN 3. A 4. C 5. A	2. IMPULSIVE 3. AGITATED 4. COMBATIVE 5. ASSAULTIVE			RESTRAINT TYPE: 1. SOFT 2. OTHER:			RUE LUE RLE LLE CHEST WAIST FOUR PC	DINT	CIRCULATION: 1. (+) IF PRESENT IN ALL EXTREMITIES 2. (-) IF NOT PRESENT IN ALL EXTREMITIES OR SIGN IN		
PUT YOUR INITIALS IN THE APPROPRIATE HOUR COLUMN. PUT NUMBER OR SIGN IN OTHER COLUMNS.													
HOUR	00	15	30	45		LOC	BEHAV IOR		RESTR AINT	SITE	CIRCUL ATION	OTHER	
COMMENTS:													
Physician's Signature Provider's Signature:							Physician's Stamp Staff's Initials:					Date	
Provider's Signature:						Staff	Staff's Initials:				Date:		
Provider's Signature:							Staff's Initial: Date:						
		ETAINE		TE,	COMI	PUTER L	ABEL	OR			LOW:		
1. Name: (Last)							(First)						
2. DOB							3. A#						
4. Nationality							Facili	ty					